

MDR Tracking Number: M5-04-0870-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on November 21, 2003.

The IRO reviewed office visits, ultrasound therapy, therapeutic exercises, therapeutic procedures, paraffin bath, electrical stimulation (unattended), hot/cold pack therapy, and paraffin for dates of service 12/16/03 through 05/07/03 that was denied based upon "V".

The IRO reviewer reversed the decision of the insurance carrier and determined that office visits, ultrasound therapy, therapeutic exercises, therapeutic procedures, paraffin bath, electrical stimulation (unattended), hot/cold pack therapy, and paraffin for dates of service 12/16/03 through 05/07/03 were medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On February 17, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

On November 9, 2004 the requestor's representative, Jo Schweizer, was contacted on the status of the fee issue portion of the dispute. The only date of service that has been paid is 04/28/03; therefore, this date of service is no longer in dispute and will not be reviewed.

- CPT Code 97035 for date of service 12/18/02 denied as "A". Per Rule 134.600(h), effective January 1, 2002, physical medicine is not one of the treatments that require preauthorization. Therefore, reimbursement in the amount of \$22.00 is recommended.
- CPT Code 99214 for date of service 04/02/03 denied as "F – Reduction according to Medical Fee Guideline". Per the 1996 Medical Fee Guideline, Evaluation & Management Ground Rules the maximum allowable reimbursement for this office visit is \$71.00. The insurance carrier paid \$0.00, which is not according to the Medical Fee Guideline. Reimbursement in the amount of \$71.00 is recommended.
- CPT Code 99213 for date of service 05/07/03 denied as "D – Duplicate charge. Another provider has previously billed for the same service on the same date". The insurance carrier did not submit convincing evidence that this charge was a duplicate charge; therefore, per the 1996 Medical Fee
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Guideline, E&M Ground Rule (IV)(c)(2) reimbursement in the amount of \$48.00 is recommended.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees outlined above as follows:

- in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Order is applicable to dates of service 12/16/03 through 05/07/03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision & Order is hereby issued this 10<sup>th</sup> day November 2004.

Marguerite Foster  
Medical Dispute Resolution Officer  
Medical Review Division

MF/mf  
Enclosure: IRO Decision

## NOTICE OF INDEPENDENT REVIEW DECISION

February 11, 2004

Rosalinda Lopez  
Program Administrator  
Medical Review Division  
Texas Workers Compensation Commission  
7551 Metro Center Drive, Suite 100, MS 48  
Austin, TX 78744-1609

RE: Injured Worker:  
MDR Tracking #: M5-04-0870-01  
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care.

TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

#### Clinical History

This patient reported an injury on \_\_\_\_ due to repetitive work as a seamstress. She was diagnosed as having a trigger finger on her right hand middle finger, pain on her right hand and arms, and weakness of both arms and hands. She eventually had carpal tunnel and right cubital tunnel surgeries with trigger finger release.

#### Requested Service(s)

Office visit, ultrasound therapy, therapeutic exercises, therapeutic procedures, paraffin bath, electrical stimulation (unattended), hot/cold pack therapy, and paraffin from 12/16/02 through 05/07/03

#### Decision

It is determined that the office visit, ultrasound therapy, therapeutic exercises, therapeutic procedures, paraffin bath, electrical stimulation (unattended), hot/cold pack therapy, and paraffin from 12/16/02 through 05/07/03 were medically necessary to treat this patient's condition.

#### Rationale/Basis for Decision

The records indicated the patient sustained multiple areas of injury as a result of repetitive trauma associated with working numerous years in a sewing plant. She was initially treated but continued to experience on going problems and requested to change her treating doctor. Her new treating doctor performed an evaluation and the results confirmed the validity of the patient's continued problems. She began an aggressive treatment program. Electrodiagnostic testing performed on 04/06/02 confirmed both the presence and the significance of her injuries. Referrals were made to specialists and surgical intervention was necessary. Post surgical rehabilitation was performed. Since there were multiple injured areas, other areas required treatment. Injections in conjunction with passive and active therapy were ordered. The doctor performing the injections concurred with the ongoing need for therapy.

The medical record documentation describing multiple injured areas, positive diagnostic testing findings, injections, surgical intervention, and documented objective and subjective findings substantiates the medical necessity for treatment. Therefore, it is determined that the office visit, ultrasound therapy, therapeutic exercises, therapeutic procedures, paraffin bath, electrical stimulation (unattended), hot/cold pack therapy, and paraffin from 12/16/02 through 05/07/03 were medically necessary.

Sincerely,

Gordon B. Strom, Jr., MD  
Director of Medical Assessment

GBS:vn